



KATE BROWN
Governor

July 6, 2021

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Via electronic delivery

Dear Administrator Brooks-LaSure,

Oregon is pleased to present a request for extension of Oregon's Medicaid 1115(a) family planning waiver application for the review and approval by your agency. Using the fast track process available for states to extend established section 1115 demonstrations, Oregon is requesting renewal of its family planning waiver for a five-year period, from January 1, 2022 through December 31, 2026.

In February 1998, the state of Oregon submitted a Medicaid waiver demonstration proposal titled "Oregon Family Planning Expansion Project" (now known as Oregon ContraceptiveCare or CCare), designed to expand the availability of Medicaid-supported contraceptive management services to a wider population base. That proposal was approved in October 1998 by the Centers for Medicare and Medicaid Services (CMS) (previously the Health Care Financing Administration) and the program began in January of 1999. The initial five-year project ran through December of 2003 and three-year extensions were approved in 2003, 2006, and 2009. Additionally, temporary extension requests were granted from November 1, 2012 through December 31, 2016. The current waiver period began on August 9, 2016 and is effective through December 31, 2021.

Oregon has long been considered a leader in its commitment to ensuring that Oregonians have access to high quality family planning services. CCare plays a central role in these efforts by providing culturally and linguistically responsive, client-centered care through a diverse network of clinics across the state that help individuals achieve their reproductive goals. Your agency's ongoing partnership and support for CCare is greatly appreciated.

Sincerely,



Governor Kate Brown

Oregon Application Certification Statement - Section 1115(a) Extension

This document, together with the supporting documentation outlined below, constitutes Oregon's application to the Centers for Medicare & Medicaid Services (CMS) to extend the Oregon Contraceptive Care ("CCare"), Medicaid section 1115 family planning demonstration (Project No. 11-W-00142/0), for a period of 5-years pursuant to section 1115(a) of the Social Security Act.

Type of Request (*select one only*):

 X **Section 1115(a) extension with no program changes**

This constitutes the state's application to the Centers for Medicare & Medicaid Services (CMS) to extend its demonstration without any programmatic changes. The state is requesting to extend approval of the demonstration subject to the same Special Terms and Conditions (STCs), waivers, and expenditure authorities currently in effect for the period August 9, 2016 through December 31, 2021.

The state is submitting the following items that are necessary to ensure that the demonstration is operating in accordance with the objectives of title XIX and/or title XXI as originally approved. The state's application will only be considered complete for purposes of initiating federal review and federal-level public notice when the state provides the information as requested in the below appendices.

- **Appendix A:** A historical narrative summary of the demonstration project, which includes the objectives set forth at the time the demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program.
- **Appendix B:** Budget/allotment neutrality assessment, and projections for the projected extension period. The state will present an analysis of budget/allotment neutrality for the current demonstration approval period, including status of budget/allotment neutrality to date based on the most recent expenditure and member month data, and projections through the end of the current approval that incorporate the latest data. CMS will also review the state's Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) expenditure reports to ensure that the demonstration has not exceeded the federal expenditure limits established for the demonstration. The state's actual expenditures incurred over the period from initial approval through the current expiration date, together with the projected costs for the requested extension period, must comply with CMS budget/allotment neutrality requirements outlined in the STCs.
- **Appendix C:** Interim evaluation of the overall impact of the demonstration that includes evaluation activities and findings to date, in addition to plans for evaluation activities over the requested extension period. The interim evaluation should provide CMS with a clear analysis of the state's achievement in obtaining the outcomes expected as a direct effect of the demonstration program. The state's interim evaluation must meet all of the requirements outlined in the STCs.

- **Appendix D:** Summaries of External Quality Review Organization (EQRO) reports, managed care organization and state quality assurance monitoring, and any other documentation of the quality of and access to care provided under the demonstration.
- **Appendix E:** Documentation of the state's compliance with the public notice process set forth in 42 CFR 431.408 and 431.420.

_____ **Section 1115(a) extension with minor program changes**

This constitutes the state's application to the Centers for Medicare & Medicaid Services (CMS) to extend its demonstration with minor demonstration program changes. In combination with completing the Section 1115 Extension Template, the state may also choose to submit a redline version of its approved Special Terms and Conditions (STCs) to identify how it proposes to revise its demonstration agreement with CMS.

With the exception of the proposed changes outlined in this application, the state is requesting CMS to extend approval of the demonstration subject to the same STCs, waivers, and expenditure authorities currently in effect for the period [insert current demo period].

The state's application will only be considered complete for purposes of initiating federal review and federal-level public notice when the state provides the information requested in Appendices A through E above, along with the Section 1115 Extension Template identifying the program changes being requested for the extension period. Please list all enclosures that accompany this document constituting the state's whole submission.

1. Section 1115 Extension Template
2. Appendix A: Historical Narrative Summary and Program Overview
3. Appendix B: Budget Allotment Neutrality Assessment and Projections
4. Appendix C: Evaluation Plan (and Attachment 1)
5. Appendix D: Summary of Quality Assurance Monitoring
6. Appendix E: Public Notice and Tribal Consult (and Attachments 1 – 6)

The state attests that it has abided by all provisions of the approved STCs and will continuously operate the demonstration in accordance with the requirements outlined in the STCs.

Signature: _____
[Governor]

Date: July 6, 2021 _____

CMS will notify the state no later than 15 days of submitting its application of whether we determine the state's application meets the requirements for a streamlined federal review. The state will have an opportunity to modify its application submission if CMS determines it does not meet these requirements. If CMS reviews the state's submission and determines that any proposed changes significantly alter the original objectives and goals of the existing demonstration as approved, CMS has the discretion to process this application full scope pursuant to regular statutory timeframes for an extension or as an application for a new demonstration.

Appendix A: Historical Narrative Summary and Program Overview

Request

The state of Oregon is seeking federal authority to extend Oregon's 1115 family planning waiver (Waiver No. 11-W-00142/0), known as Oregon ContraceptiveCare or CCare, for the period of January 1, 2021 through December 31, 2026. The state is not proposing any programmatic changes to the family planning waiver with this extension request, and is not requesting any changes to the expenditures and waiver authorities already granted by the Centers for Medicare and Medicaid Services (CMS).

Program History

In February 1998, the state of Oregon submitted a Medicaid waiver demonstration proposal titled "Oregon Family Planning Expansion Project" (now known as Oregon ContraceptiveCare or CCare), designed to expand the availability of Medicaid-supported contraceptive management services to a wider population base. That proposal was approved in October 1998 by the Centers for Medicare and Medicaid Services (CMS) (previously the Health Care Financing Administration) and the program began in January of 1999. The initial five-year project ran through December of 2003 and three-year extensions were approved in 2003, 2006, and 2009. Temporary extension requests were granted from November 1, 2012 through December 31, 2016. The current waiver period began on August 9, 2016 and is effective through December 31, 2021.

Prior to CCare's inception in 1999, Oregon served an average of 50,000 clients a year, less than 30% of the Women in Need,¹ through approximately 90 publicly funded family planning clinics. Only 82% of sexually active high-school students reported using contraception at last intercourse. The pregnancy rate among 15-17 year olds was 42.1 per 1,000 and the adult unintended pregnancy rate was 44.3 per 1,000. However, with the introduction of the waiver, system capacity and impact increased dramatically. By 2005, Oregon was serving nearly 157,000 clients with all sources of pay at 165 publicly supported clinics – approximately 67% of Women in Need. Ninety percent (90%) of sexually active high-school students reported using contraception at last intercourse and the 15-17 year old pregnancy rate had dropped to 24.2 per 1,000.

Unfortunately, however, these 2005 data represent the height of CCare's client caseload. Waiver utilization and impact diminished significantly beginning in 2006 when federal

¹ Women in Need is an estimate of the number of fertile, reproductive-age women with incomes under 250% FPL who are neither pregnant nor intentionally trying to become pregnant. It is produced by the Guttmacher Institute.

citizenship documentation requirements and other waiver eligibility restrictions were implemented. In 2008, only 112,000 individuals with all sources of pay (45% of Women In Need) received family planning services. By April of that year, CCare visits had declined from the 2005 peak by 33% overall and by a startling 47% and 49% among teens and African-Americans, respectively. The precipitous drop in these two client groups further demonstrates how the citizenship documentation requirements of the 2005 Deficit Reduction Act (DRA) negatively impacted those who are truly eligible for the program.

Implementation of the Affordable Care Act, including Medicaid expansion and the creation of the health insurance marketplace, effectively provided coverage to thousands of Oregonians who were previously uninsured. As expected, many previously enrolled CCare clients shifted to the state's full-benefit Medicaid program, the Oregon Health Plan (OHP). CCare monthly enrollments declined sharply starting in 2014, although enrollment numbers began to level off by mid-2015. The ongoing need for CCare coverage is supported by research from the health reform experience of Massachusetts² that showed that even with greatly expanded health insurance coverage, significant coverage gaps remain for many individuals in need of family planning, and CCare is uniquely positioned to address these gaps.

In 2017, the Oregon legislature passed the Reproductive Health Equity Act ([HB 3391](#)) which: (1) required that Oregon-based health benefit plans to cover a suite of preventive health services, without any cost-sharing requirements, similar to those defined in the Affordable Care Act's preventive services coverage requirements and (2) required the Oregon Health Authority to administer a program to reimburse for a full range of reproductive health services for individuals of reproductive capacity who are not otherwise eligible for medical assistance (i.e., those not eligible for Medicaid because of their immigration status).

Following passage of HB 3391, the RH Program worked to operationalize this legislation through an innovative integrated structure with its other funding, including CCare. Implementation of this new structure began on April 1, 2018. While the bill does not affect CCare's policies or covered services, the RH Program developed a single, streamlined client RH Program Enrollment Form that allows individuals to enroll in the RH Program and receive covered benefits based on their eligibility (i.e., U.S. citizens that meet all other CCare eligibility requirements are eligible for CCare while those with an immigration status that disqualifies them from full-benefit Medicaid are eligible for HB 3391 and other state-funded benefits).

² Leighton Ku, et al., "Safety-Net Providers After Health Care Reform: Lessons from Massachusetts," *Archives of Internal Medicine*, August 8, 2011, Vol 171, Number 15.

As part of implementation in April 2018, all CCare agencies were provided the opportunity to apply and become certified under the newly integrated RH Program structure (now known as RHCare). Agencies that declined to become certified as RHCare clinics remained CCare-only and continue routine CCare operations. Clients seeking services at CCare-only clinics complete the integrated RH Program Enrollment Form but are only eligible for CCare-covered services unless they seek services at an RHCare clinic.

In early 2021, the RH Program developed and released [CCare Certification Requirements](#) for CCare agencies. The new certification requirements were based largely on CCare's longstanding Standards of Care (which had previously been included in CCare's Oregon Administrative Rules) and were modeled after the structure of RHCare clinic certification requirements developed in 2018. In order to become (or remain) contracted with the RH Program as a CCare clinic, agencies must meet the CCare certification requirements and complete an application for certification. The CCare Certification Requirements outline the minimum administrative and clinical requirements clinics must meet in order to be certified by the RH Program and to receive reimbursement for CCare services provided to individuals who meet CCare eligibility criteria. All existing CCare agencies are expected to apply and be approved for certification within the first half of calendar year 2021. New and interested agencies may apply for and become certified as CCare with the RH Program at any time.

Client Eligibility

To be considered eligible for CCare, an individual must:

- Have a household size and personal income at or below 250 percent of the FPL;
- Not be enrolled in the state's full-benefit Medicaid program, OHP;
- Have reproductive capacity;
- Reside in Oregon as described in Oregon Administrative Rule 461-120-0010 (Residency Requirements);
- Provide a valid Social Security Number (SSN) as required by 42 USC 1320b-7; and
- Be a citizen of the United States, with acceptable proof of citizenship verification and identity; or
- Hold eligible immigration status with acceptable proof of eligible immigration verification and identity.

Clients are enrolled in CCare at the point of service (clinic site) but final determinations of eligibility are made by state staff. CCare eligibility is effective for one year once established. Eligibility re-determination occurs annually, sooner if a client has lost CCare eligibility for some reason (e.g., acquired and then lost OHP coverage) and is seeking to reestablish it.

Oregon requests to maintain authority for the same eligible population.

Covered Services

The scope of CCare covered services includes:

- A broad range of contraceptives, including device insertion and removals and vasectomies;
- Counseling and education to assist with preventing pregnancy;
- Sexually transmitted infection (STI) screening, as indicated; and
- Breast and cervical cancer screening, within the context of a family planning visit.

A complete list of all reimbursable service codes for CCare can be found on the RH Program's web site at:

<https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/REPRODUCTIVESEXUALHEALTH/RESOURCES/Documents/billing/Allowable-ICD10-CC.pdf>.

Oregon requests to maintain authority for the coverage described above, in addition to STI treatment and rescreening and follow-up Pap tests pursuant to a family planning visit at the applicable federal matching rate.

Provider Network

There are currently 46 provider agencies enrolled in CCare, representing a total of 153 clinic sites. Among these 46 agencies, 33 are certified as RHCare clinics, affording them access to the RH Program's multiple sources of funding, including CCare. Clinics are located in 33 of the 36 counties across the state and include local public health departments, federally qualified health centers, school-based health centers, Planned Parenthood clinics, University health centers, and small community-based clinics.

Objectives

The objectives outlined in the last waiver renewal period, including evidence of the state's progress in meeting them, can be found in Appendix C, Attachment 1. For the next waiver renewal period, the RH Program has made several revisions to measures to better align with the RH Program's vision that all Oregonians have reproductive autonomy³. As Christine Dehlendorf, a researcher at the University of California, San Francisco has noted, while preventing unintended pregnancy has long been considered the gold standard outcome for family planning programs, more recent research indicates that:

³ Reproductive autonomy is having the power to decide and control contraceptive use, pregnancy, and childbearing. For example, women with reproductive autonomy can control whether and when to become pregnant, whether and when to use contraception, which method to use, and whether and when to continue a pregnancy. *From The Bixby Center for Global Reproductive Health, University of California, San Francisco.*

“concepts of “intention” and “planning” do not fully capture the reality of pregnancy in women’s lives. Rather, intention may be better understood as a spectrum. Further, whether or not a pregnancy is “unintended” can be unrelated to whether a woman would have positive or negative feelings about a pregnancy [12, 13]. As a result, for some women, having an unintended pregnancy may not be an adverse outcome. Therefore, using a metric of whether a pregnancy was intended to judge whether a pregnancy should be judged as “bad” or “good” has significant limitations from a patient-centered perspective.”⁴

The RH Program is committed to identifying and adopting patient-centered outcome measures that better reflect the complexity and nuances of people’s lived experiences with regards to their reproductive well-being. However, until more appropriate measures can be defined, the RH Program will continue to utilize the standard measure of reducing unintended births to assess CCare’s long-term impact. In order to add more context to this single dimension, the RH Program is replacing many of its existing outcome measures related to the use of moderate and highly effective contraceptive methods with measures that assess *access* to a wide range of methods. These measures more appropriately place the onus on systems of care as opposed to the idea that people must choose the most effective method of contraception. This concept ignores the reality that people have diverse preferences for the characteristics of their contraceptive method, such as side effects, efficacy, and mode of administration and thus may choose a less-effective method that better fits their values, lifestyle, and circumstances.

Similarly, the concept and use of a measure focused on teen pregnancy is one that continues to stigmatize youth by perpetuating the premise that teen pregnancy is inherently something that needs to be prevented. Instead, young people need access to high-quality, culturally responsive reproductive health information and services in order to “safely navigate their own reproductive lives, healthy relationships and families. Resources, policies, and priorities will better serve young people by addressing the root causes of inequity that impact quality of life and overall outcomes in our communities.”⁵ Based on this, the RH Program has retired the outcome measure related to decreasing teen pregnancy and has added a measure related to access to a wide range of methods at school-based health centers (SBHCs) where many Oregon youth access reproductive health care.

CCare’s future outcomes can be grouped into three categories: (A) immediate outcomes for CCare clients; (B) intermediate outcomes for both CCare clients and the waiver’s target

⁴ Dehlendorf Christine, et al., “Ensuring our research reflects our values: The role of family planning research in advancing reproductive autonomy,” *Contraception*, July 2018, Vol 98(1); 4-7.

⁵ Cadena, Micaela, Raquel Z. Rivera, Tannia Esparza and Denicia Cadena. *Dismantling Teen Pregnancy Prevention*. Albuquerque, New Mexico: Young Women United, 2016.

population; and, (C) long-term outcomes for Oregon’s reproductive-age population as a whole. Further details regarding these outcomes, and the performance targets established for them, can be found in Appendix C of this application.

(A) Immediate Outcomes

- Outcome 1: The program will result in an increase in the proportion of CCare clinics that dispense the full range of contraceptive methods onsite.
Data source: RH Program
- Outcome 2a: The program will result in an increase in the proportion of clients who receive help to access primary care services.
Data source: RH Program
- Outcome 2b: The program will result in an increase in the proportion of clients who receive help to access comprehensive health insurance coverage.
Data source: RH Program

(B) Intermediate Outcomes

- Outcome 3: The program will result in an increase in the proportion of reproductive-age Oregonians who report that in the last year, a doctor, nurse, or other health care worker asked them if they want to become pregnant in the future.
Data source: Oregon Behavior Risk Factor Surveillance System (BRFSS)
- Outcome 4: The program will result in an increase in the proportion of Oregon School-Based Health Centers that dispense the full range of contraceptive methods onsite.
Data source: Oregon School-Based Health Center Program Office

(C) Long-term Outcomes

- Outcome 5: The program will result in a decrease in the proportion of Oregon births classified as unintended.
Data source: Oregon Pregnancy Risk Assessment Monitoring System (PRAMS)

Expenditure Authorities

The Demonstration’s expenditure authority falls under the State’s Title XIX plan and section 1115(a)(2) of the Social Security Act. Requirements not applicable to the expenditure authorities are:

1. Methods of Administration: Transportation: Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53. To the extent necessary to enable the State to not assure transportation to and from providers for the demonstration population.

2. Amount, Duration, and Scope of Services (Comparability): Section 1902(a)(10)(B). To the extent necessary to allow the State to offer the demonstration population a benefit package consisting only of family planning services and family planning-related services.
3. Prospective Payment for Federally Qualified Health Centers and Rural Health Center and Rural Health Clinics: Section 1902(a) (15). To the extent necessary for the State to establish reimbursement levels to these clinics that will compensate them solely for family planning and family planning-related services.
4. Eligibility Procedures: Section 1902(a) (17). To the extent necessary to allow the State to include only the applicant's income when determining eligibility for the family planning demonstration. To the extent necessary to allow the State to not require reporting of changes in income or household size for 12 months, for a person found income-eligible upon application or annual redetermination when determining eligibility for the family planning demonstration.
5. Retroactive Coverage: Section 1902(a) (34). To the extent necessary to enable the State to not provide medical assistance to the demonstration population for any time prior to the first of the month in which an application for the demonstration is made.
6. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT): Section 1902(a)(43)(A). To the extent necessary to enable the State to not furnish or arrange for EPSDT services to the demonstration population

Appendix B: Budget Allotment Neutrality Assessment and Projections

Historical Enrollment and Expenditure Data

I. Enrollment

	2016	2017	2018	2019	2020
January	2,642	2,728	2,536	2,532	2,284
February	2,472	2,725	2,221	2,093	2,165
March	2,630	2,859	2,494	2,123	1,393
April	2,441	2,454	4,072	2,508	746
May	2,497	2,637	3,918	2,595	923
June	2,404	2,412	3,220	2,333	1,276
July	2,123	2,265	2,566	2,429	1,553
August	2,549	2,429	2,537	2,287	1,499
September	2,639	2,384	2,491	2,121	1,409
October	2,734	2,665	2,899	2,628	1,519
November	2,769	2,307	2,276	2,166	1,046
December	2,218	2,001	1,882	1,984	817
Average	2,510	2,489	2,759	2,317	1,386

II. Reported Expenditures

	2016*	2017	2018	2019	2020
Total	\$11,232,978	\$7,962,148	\$8,889,027	\$9,755,882	\$7,017,043
Non-Federal	\$1,123,298	\$1,346,088	\$1,400,741	\$1,528,988	\$1,200,121
Federal	\$10,109,680	\$6,616,060	\$7,488,286	\$8,226,893	\$5,816,921

* It should be noted that in 2016 an error was discovered on the CMS64 report where CCare waiver expenditures were not reported correctly. The OHA Office of Financial Services corrected this by moving all direct service payments made during the period July 1, 2015 through September 30, 2016 to the correct coding structure that would allow these payments to be reflected on the CMS64 report. Because of this adjustment, expenditures in calendar year 2015 are now reflected on the CMS64 Quarter 1 (DY 18, Q4) report as a prior period adjustment resulting in an inflation of the calendar year 2016 expenditures. The 2015 expenditures being reflected in calendar year 2016 represent \$3,637,752, meaning that the annual total for DY 18/CY 16 should actually be \$8,420,287 in expenditures.

Historical Per Member Per Month and Expenditures

	2016	2017	2018	2019	2020
Total enrollments	30,115	29,886	33,112	27,799	16,630
Total number of member months	301,149	284,604	220,732	334,384	312,121
Total expenditures	\$8,420,287	\$7,962,148	\$8,889,027	\$9,755,882	\$7,017,043
Per Member/Per Month (PMPM) Cost (Total Computable)	\$27.96	\$27.98	\$40.27	\$29.18	\$22.48
% change in PMPM from year to year		0.1%	43.9%	-27.6%	-22.9%

4-year average % change in PMPM from year to year: -6.5%

As shown above, there were substantial fluctuations in the Per Member/Per Month Costs each year. In 2018, the Reproductive Health Program integrated CCare into a new structure, which required ending all current CCare client eligibility as of March 31, 2018, and subsequent re-enrollment the next time each client returned to a CCare clinic. As a result of these re-enrollments, the number of total enrollments increased, but member-months decreased substantially – thus increasing the PMPM costs well above the increase in total expenditures. In 2019, we saw total enrollments and member-months return to typical levels. In 2020, the COVID-19 pandemic resulted in two primary factors that affected enrollments and member months: (1) early on in the pandemic, many clinics limited hours and/or services to ensure pandemic safety, and (2) eligibility extensions were granted as a result of the Public Health Emergency. These two factors resulted in fewer total enrollments but a relatively high number of member-months, thus an extremely low PMPM cost for 2020.

Projected Number of Enrollments and PMPM Costs

	2022	2023	2024	2025	2026
Number of clients enrolling or re-enrolling	27,800	26,688	25,887	25,370	25,116
Projected % change in annual enrollments	0% change from 2019	-4%	-3%	-2%	-1%
Per Member/Per Month (PMPM) Cost (Total Computable)	\$29.76	\$30.35	\$30.96	\$31.58	\$32.21
% change in PMPM from year to year		2.0%	2.0%	2.0%	2.0%

Due to the fluctuations in enrollments over the last year due to the COVID-19 pandemic, and the previous fluctuations as described above, it is challenging to project into the future. We are projecting that annual enrollments will return to 2019 levels in 2022, and subsequent years will see declining enrollments, but at decreasing rates each year. The projected PMPM Cost in 2022 is based on 2019 PMPM plus 2% for inflation. We are projecting a 2% annual increase in the Per Member/Per Month Costs, based on typical inflation rates. Barring another pandemic or other substantial policy change that affects enrollments or service costs, we are projecting a greater level of stability than has been seen in the current waiver renewal period.

Appendix C: Evaluation Plan

The state's interim evaluation of CCare can be found in Attachment 1 of this Appendix.

As described in Appendix A, the state has developed revised outcome measures for the next waiver renewal period that better reflect the RH Program's vision that all Oregonians have reproductive autonomy. Many of the program's original objectives have been retired due to their limited relevance and applicability to the current program. The RH Program's proposed outcome measures can be grouped into three categories: (A) immediate outcomes for CCare clients; (B) intermediate outcomes for both CCare clients and the waiver's target population; and, (C) long-term outcomes for Oregon's reproductive-age population as a whole. Performance targets have been set for each outcome and will be monitored annually to measure progress toward these goals.

(A) Immediate Outcomes

- Outcome 1: The program will result in an increase in the proportion of CCare clinics that provide the full range of contraceptive methods onsite.
Data source: RH Program, Agency Certification Data
Performance target: 95.0%
Current rate (2021): 90.2%
Notes: CCare clinics that report providing the full range of contraceptive methods, including long acting reversible contraceptives (LARCs), at the clinic site.
- Outcome 2a: The program will result in an increase in the proportion of clients who receive help to access primary care services.
Data source: RH Program, Client Enrollment Form
Performance target: 50.0%
Current rate (2020): 24.1%
Notes: Clinic staff indicate "Gave information on where to access primary care services: Yes/Not needed" on the Client Enrollment Form. Although the current rates for both Outcome 2a and 2b are the same, the measures are two separate and distinct fields on the Client Enrollment Form.
- Outcome 2b: The program will result in an increase in the proportion of clients who receive help to access comprehensive health insurance coverage.
Data source: RH Program, Client Enrollment Form
Performance target: 50.0%
Current rate (2020): 24.1%

Notes: Clinic staff indicate “Gave health insurance enrollment information: Yes/Not needed” on the Client Enrollment Form. Although the current rates for both Outcome 2a and 2b are the same, the measures are two separate and distinct fields on the Client Enrollment Form.

(B) Intermediate Outcomes

- Outcome 3: The program will result in an increase in the proportion of reproductive-age Oregonians who report that in the last year, a doctor, nurse, or other health care worker asked them if they want to become pregnant in the future.

Data source: Oregon Behavior Risk Factor Surveillance System (BRFSS)

Performance target: 50.0%

Current rate (2019): 29.5%

Notes: Pregnancy intention screening among female respondents between 18 and 49 years of age without a hysterectomy and who have not been sterilized.

- Outcome 4: The program will result in an increase in the proportion of Oregon School-Based Health Centers that provide the full range of contraceptive methods onsite.

Data source: Oregon School-Based Health Center Program Office, Operational Profile

Performance target: 35.0%

Current rate (2021): 17.9%

Notes: Includes SBHCs that report dispensing/administering the full range of methods onsite, including condoms, oral contraceptives, EC, implant, Depo, IUD/IUS, Patch, and Ring.

(C) Long-term Outcome

- Outcome 5: The program will result in a decrease in the proportion of Oregon births classified as unintended.

Data source: Oregon Pregnancy Risk Assessment Monitoring System (PRAMS)

Performance target: 30.0%

Current rate (2018): 34.6%

Notes: Proportion of respondents who reported that their most recent birth was mistimed, unwanted or where the respondent reported they “weren’t sure what they wanted” are classified as unintended.

Appendix C, Attachment 1: Interim Evaluation Report

Introduction

It should be noted that the below objectives were developed as part of the state's waiver renewal application to CMS in 2016. Many of these objectives have been retired due to their limited relevance and applicability to the RH Program's current goals. These new objectives are detailed in the previous pages.

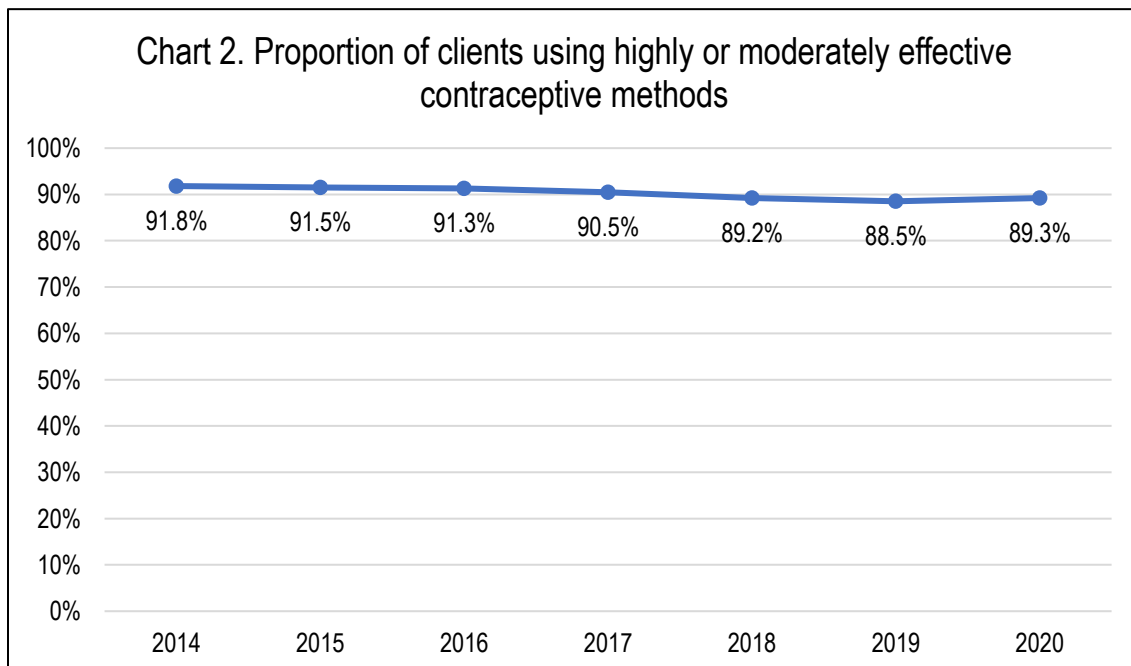
(A) Immediate Outcomes:

- Outcome 1: The program will result in an increase in the proportion of clients who use a highly effective or moderately effective contraceptive method.

Data source: RH Program Data System, Clinic Visit Record (CVR) data

Performance target: 92.5%

Progress: This outcome measure uses encounter data for clients with CCare source of coverage served within publicly supported family planning clinics. Effective contraceptive use is defined as all [Tier 1 and Tier 2 contraceptive methods](#) among unduplicated female clients of all ages at risk of unintended pregnancy. Women at risk of unintended pregnancy excludes clients who are using no method because they are pregnant, seeking pregnancy, or not currently sexually active. In 2014, when this measure was first tracked, 91.8% of all clients used a most or moderately effective method. This rate has declined slightly since 2014, with 89.3% of all clients using a most or moderately effective method in 2020.

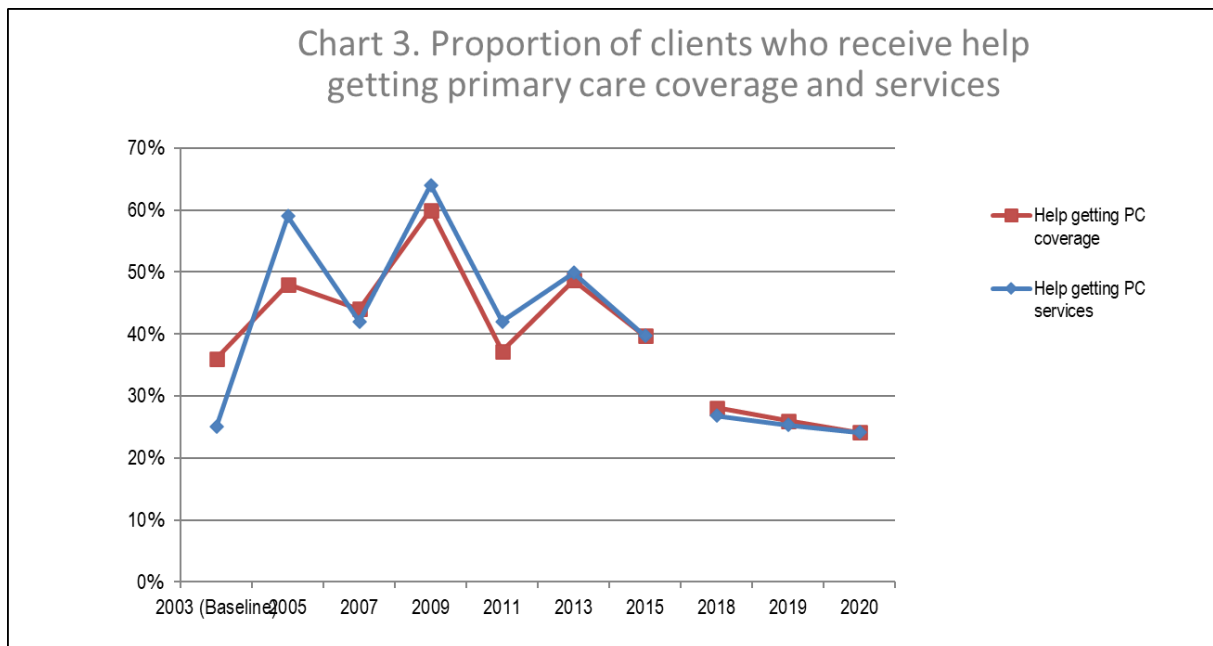


- Outcome 2: The program will result in an increase in the proportion of clients who receive help to access primary care services and comprehensive health coverage.

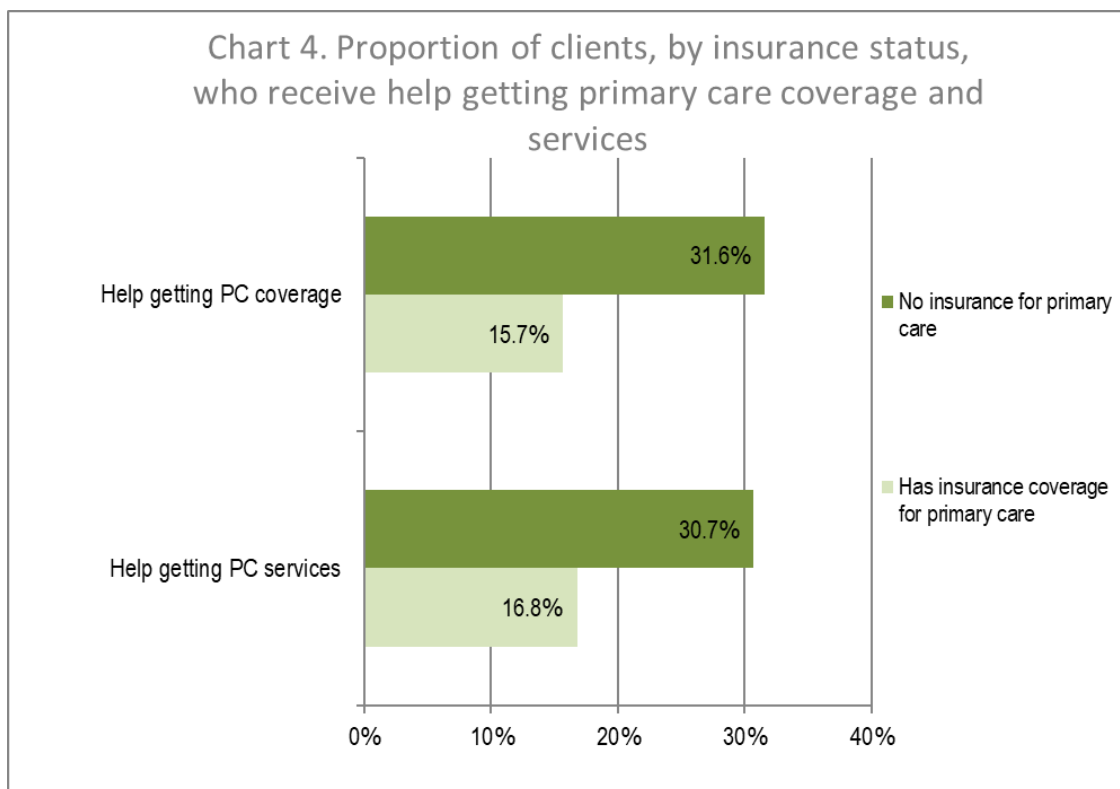
Data source: RH Program Customer Satisfaction Survey (2003-2015), RH Program Enrollment Form (2018-present)

Performance target: 50%

Progress: This outcome was established at the time of CCare's first renewal to monitor progress toward the newly added goal of ensuring that clients received assistance with access to primary care services and coverage. To track this outcome, we use data from our own Customer Satisfaction Survey (CSS), a system-wide, self-administered client exit survey conducted approximately every other year. Sample selection for the CSS takes place at the clinic level and is typically designed to ensure representation of all but the very smallest volume clinics (those with less than 10 visits per week). Both CCare and non-CCare clients participate at the sampled clinics. The most recent data available come from the CSS administered in the fall of 2015. Results from 2003 (baseline) through 2015 are shown in Chart 3. Beginning in 2018, this information is collected on the RH Program Enrollment Form rather than the CSS, so the 2018 figures cannot be compared to previous years. Because this is a new data source, we will be tracking this moving forward to reestablish trends.



In 2020, less than 30% of CCare enrollees indicated that they had received help getting primary care services and coverage. This represents a substantial decline compared to the client survey results, which can be attributed to two factors. First, the wording of these questions has changed from how it was collected in our client survey, highlighting the need to review the phrasing of these questions and possibly reword them in future iterations of the RH Program Enrollment Form. Second, as more individuals gain comprehensive insurance coverage and access to primary care services through ACA and Medicaid expansion, it is possible that clinic staff are not offering assistance to individuals to get primary care coverage or services if there is no need (i.e. the client already has both coverage and access to services). As shown in Chart 4, those without insurance for primary care were much more likely to have received information about both public health insurance and accessing general health services than those with insurance.



RH Program staff continue to conduct ongoing RH Program Enrollment Form audits on a random sample of medical records. These audits include a review of the primary care referral requirement to ensure that this objective is met. Furthermore, the primary care referral requirement continues to be a focus for provider trainings.

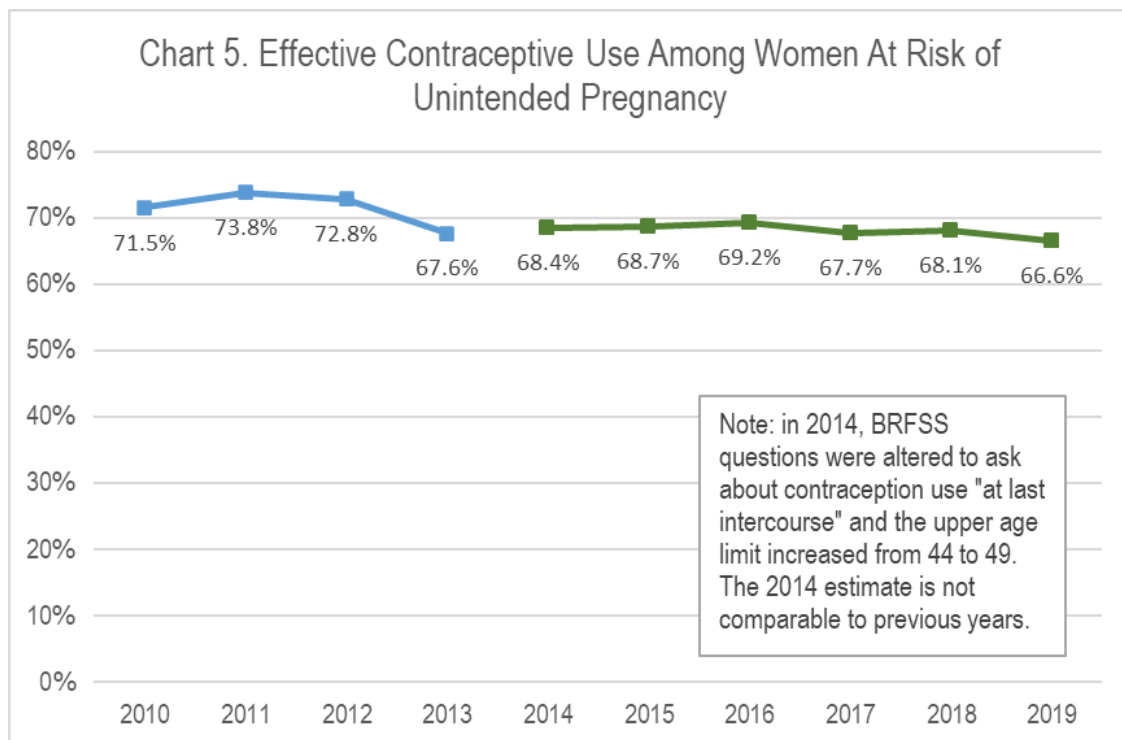
(B) Intermediate Outcomes

- Outcome 3: The program will result in an increase in the proportion of reproductive-age Oregonians who use a highly effective or moderately effective contraceptive method.

Data source: Oregon Behavior Risk Factor Surveillance System (BRFSS)

Performance target: 76.0%

Progress: To monitor this outcome, we use data from the Oregon Behavioral Risk Factor Surveillance System (BRFSS), a CDC-sponsored, population-based, telephone survey of non-institutionalized adults in the state. The specific BRFSS item used to track this outcome first appeared on the questionnaire in 1998 and asks respondents what method they and/or their partners currently use to prevent pregnancy. Beginning in 2002, both male and female respondents answered this item but we restrict our analysis to female respondents to facilitate year-to-year comparisons. Effective contraceptive use is defined as use of all Tier 1 and Tier 2 methods among women 18-49 at risk of unintended pregnancy. Women at risk of unintended pregnancy excludes respondents who have a same sex partner, don't know their birth control use, refuse birth control use, have had a hysterectomy, are currently pregnant, reporting being too old, want to get pregnant, and/or don't care if they get pregnant.

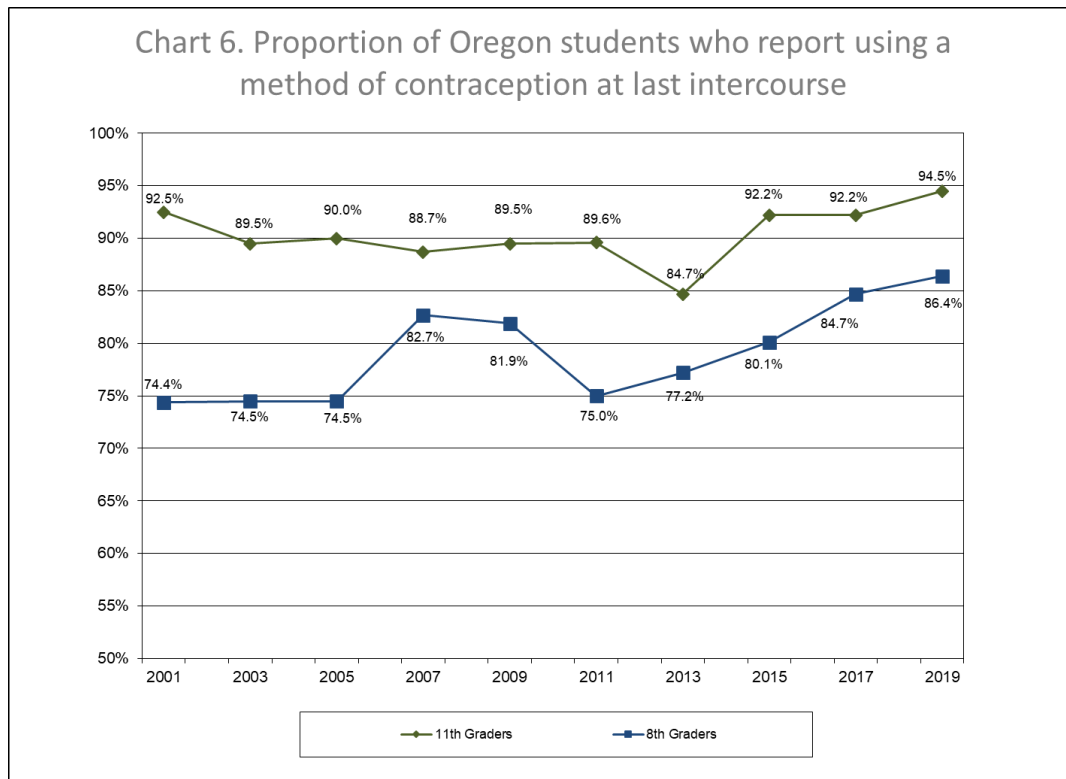


- Outcome 4: The program will result in an increase in the proportion of sexually experienced high school students who report using a method of contraception at last intercourse.

Performance targets: 8th grade – 80.0% and 11th grade – 89.5%

Data source: Oregon Healthy Teens survey (OHT)

Progress: To determine whether expanded availability of subsidized birth control and contraceptive management services affects birth control use among teens, data from the Oregon Healthy Teens Survey (OHT), a school-based survey, is used. OHT focuses on 8th and 11th grade students. Between 2001 and 2009, OHT was conducted annually; it is now administered every odd year. The OHT questionnaire includes an item asking participants what *one* method of contraception they used to prevent pregnancy at last intercourse. For the purposes of this analysis, students who responded as never having had sex were excluded. Students who said they used a highly effective method (IUD and implant), moderately effective method (Depo, pills, patch, and ring), less effective method (condoms and withdrawal), or an unspecified “other” method were counted among contraceptive method users. Those who responded that they didn’t know or were not sure about the method used were counted among the “no method” group. It should be noted that starting in 2017, students were asked to mark “all that apply” so each response was calculated individually, though those who responded that they didn’t know or were not sure about the method used were still counted among the “no method” group. Rates of contraceptive use among Oregon students continues to increase; in 2019 94.5% of 11th graders and 86.4% of 8th graders reported using contraception at last intercourse (including only those students who reported ever having sex).



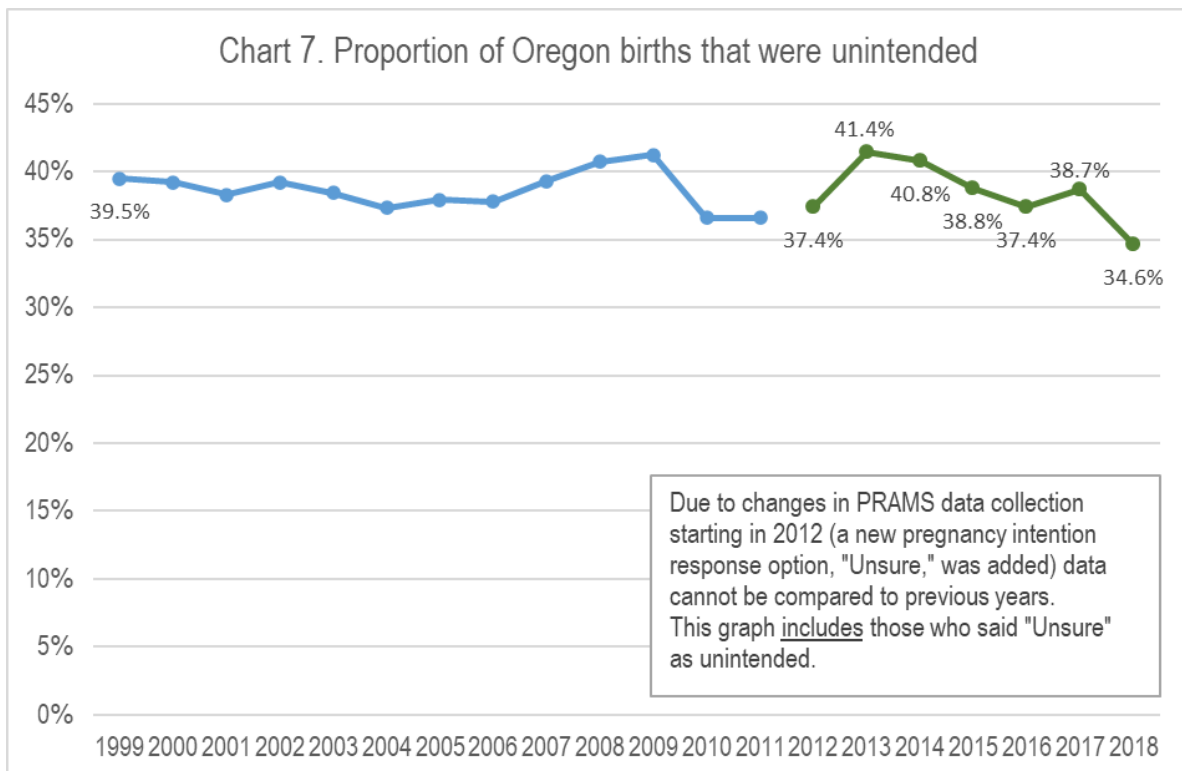
(C) Long-term Outcomes

- Outcome 5: The program will result in a decrease in the proportion of Oregon births classified as unintended.

Data source: Oregon Pregnancy Risk Assessment Monitoring System (PRAMS)

Performance target: 36.0%

Progress: National standard methodology is used to assess pregnancy intent: women are asked to think back before their recent pregnancy and report whether they had wanted to become pregnant at that time, sooner, later, or not at all. Pregnancies that occur too soon are classified as mistimed, those that are not wanted at all are labeled unwanted, and those two categories together form the unintended group. Pregnancies that occur too late or “at about the right time” are considered intended. In 2012, an additional response option was included to the question assessing pregnancy intent: “unsure”. Based on analysis of previous years’ response breakdowns, the unsure responses have been grouped as part of the unintended category. Because of this change, results for 2012 and after cannot be compared with data from prior years. Chart 7 below details the proportion of Oregon births that were unintended, starting in 1999. The proportion of births classified as unintended has been declining over the last few years.



- Outcome 6: The program will result in a decrease in the unintended pregnancy rate in Oregon.

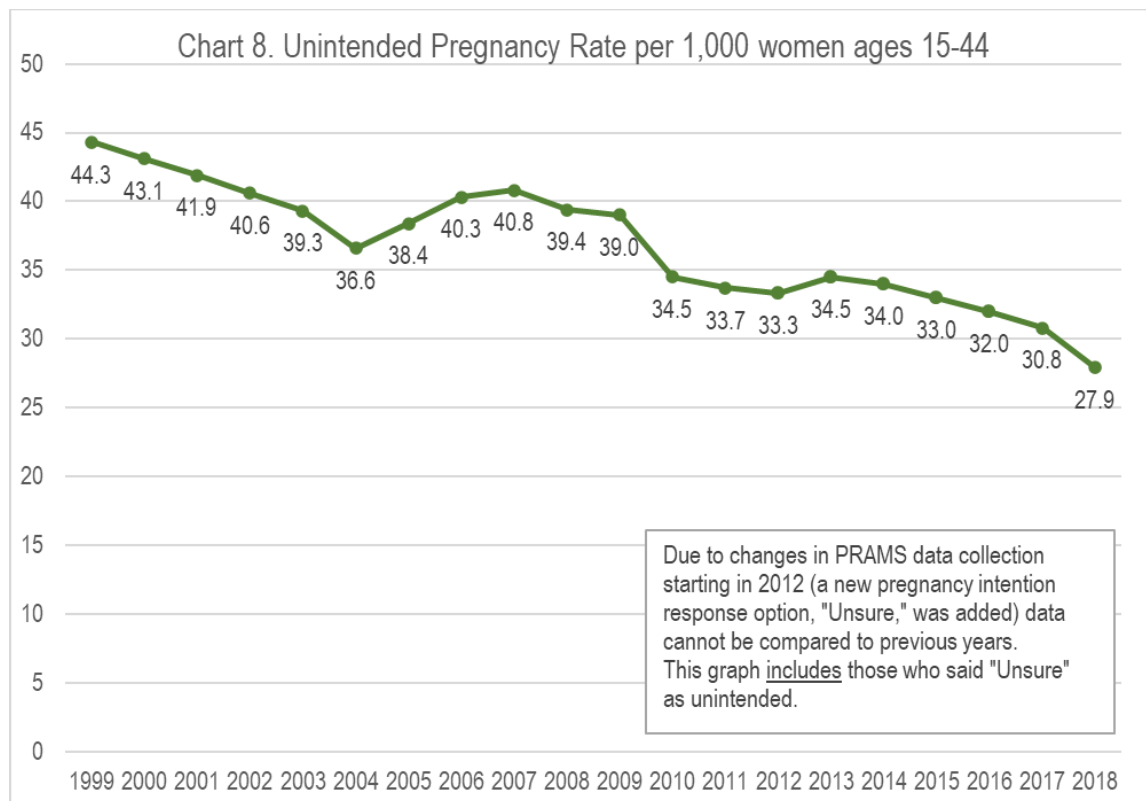
Data source: Oregon PRAMS and Oregon Center for Health Statistics

Performance target: 32.0 per 1,000 women 15-44

Progress: To estimate the unintended pregnancy *rate*, we use a three-step procedure very similar to the one outlined by Stanley Henshaw in his well-known article “Unintended Pregnancy in the United States.”¹ In the first step, we estimate the proportion of Oregon’s births (not pregnancies) that are unintended using PRAMS data. We then multiply the actual number of births in each year (obtained from the Center for Health Statistics, or CHS) by the unintended proportion to produce an annual number of unintended births in the state. Next, we multiply the annual number of abortions in the state by approximately 0.95 to derive an annual estimate of the number of unintended abortions in the state.² Finally, we add the unintended birth and abortion numbers together and divide the result by state population figures to produce an estimated unintended pregnancy rate per 1,000 women aged 15-44. The results of this analysis are shown in Chart 8. Between 2005 and 2007, the unintended pregnancy rate increased slightly to 40.8 per 1,000 women in 2007, but decreased to 33.1 per 1,000 women in 2012. This recent decrease can be attributed largely to the decline in the total number of pregnancies since 2007 and the drop in the unintended birth rate in 2010 and 2011. As with the measure above, data for 2012 and after cannot be compared with data from prior years because of the addition of the new response option “unsure” used to calculate the unintended pregnancy rate. However, it appears that unintended pregnancies have been declining in the last few years, with current rates below the target of 32.0 per 1,000 women age 15-44.

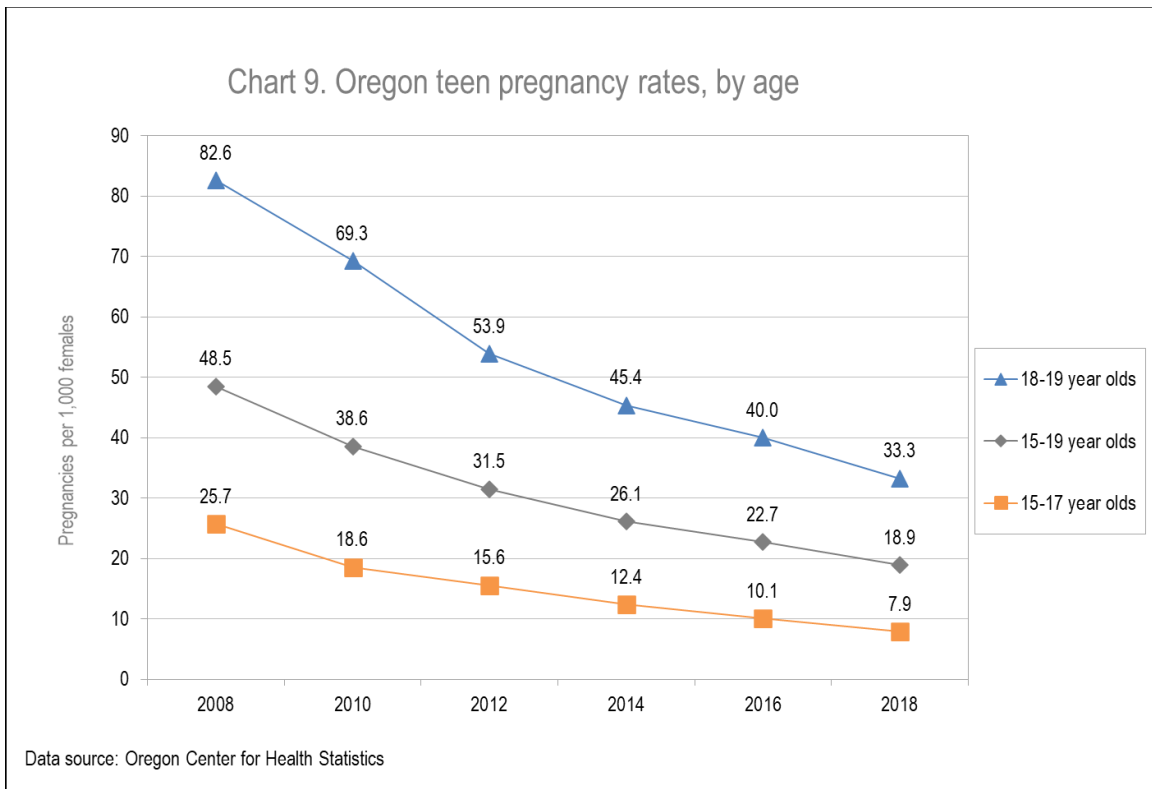
¹ Henshaw, S. (1998). Unintended Pregnancy in the United States. Family Planning Perspectives, 30(1), 24-29 & 46.

² Approximately 95% of abortions are estimated to result from unintended pregnancies. Personal communication: M. Zolna to R. Linz, 01/10/14.



- Outcome 7: The program will result in a decrease in teen pregnancy rates in Oregon.**
 Data source: Oregon Center for Health Statistics
 Performance target: 15-17 year olds – 11.0 and 18-19 year olds – 43.5
 Progress: Teen pregnancy has declined dramatically over the last 20 years. In all three age groups, the drop that occurred in the three years following CCare implementation (1999-2002) was greater than the decline experienced in the previous three-year period (1996 to 1999). Starting in 2005, Oregon teen pregnancy rates increased for the first time in about 10 years, depending on the age group. This trend was reflected nationally, where both teen birth and pregnancy rates rose in 2006, for the first time since 1991.³ This increase has since reversed, however, with Oregon teen pregnancy rates among all age groups continuing to dramatically decline between 2008 and 2018. As shown in the chart below, these rates are currently at their lowest rates ever since tracking began for this measure (7.9 per 1,000 per 15-17 year olds, 33.3 per 1,000 for 18-19 year olds; and 18.9 per 1,000 for 15-19 year olds).

³ Guttmacher Institute data report. "U.S. Teenage Pregnancies, Births, and Abortions: National and State Trends and Trends by Race and Ethnicity." January 2010. Accessible at: <http://www.guttmacher.org/pubs/USTPTrends.pdf>



Appendix D: Summary of Quality Assurance Monitoring

Currently, Oregon’s public family planning provider network is made up of 46 agencies—the administrative units of programs or providers—and 153 clinic sites, the physical facilities where services are provided. Among these 46 agencies, 33 are certified to participate in the full RH Program as RHCare clinics, affording them access to all of the RH Program’s sources of funding, including CCare. Clinics are located in 33 of the 36 counties across the state. The network includes a broad range of provider types: local public health departments, federally-qualified health centers and rural health clinics, University health centers, and school-based health centers, Planned Parenthood clinics, and a small number of private providers.

The CCare clinic network is often the single entry point for many individuals of reproductive age into the health care system. As such, CCare is uniquely positioned at this key entry point to meet the immediate family planning needs of these individuals while also assisting them with obtaining more comprehensive insurance coverage. CCare provides vital access to providers who are uniquely qualified to serve the clients who need their services: by being available when and where their clients need them; by speaking their languages and understanding their values and perspectives; by discussing sexuality comfortably and without judgment; and, by offering accurate information and the full range of contraceptive methods onsite. Further, these clinics have developed relationships within their respective communities that facilitate access to high risk, disenfranchised populations (e.g. justice system, alternative schools), all of which increase the likelihood of acquiring care.

All CCare clinics, as outlined in the terms of their contract with the state, agree to comply with the [CCare Certification Requirements](#). The CCare Certification Requirements provide a foundation for contraceptive services based on national standards of care and align with best practices and recommendations for client-centered, culturally-responsive, high-quality contraceptive care. In particular, the CCare Certification Requirements outline the full scope of clinical and preventive services that must be offered to CCare clients. These services include, but are not limited to, a comprehensive health history; an initial physical exam, as clinical indicated; routine laboratory tests related to the decision-making process for contraceptive choices; and a broad range of FDA-approved contraceptive methods, devices, supplies and procedures. As stated above, the contraceptive methods and their applications, consistent with recognized medical practice standards, as well as fertility awareness methods, must be available onsite at the clinic for dispensing to the client at the time of the visit.

Oregon ContraceptiveCare Integrity Plan

The RH Program has an obligation to state and federal funders, as well as to Oregon taxpayers, to oversee the administration of CCare to assure compliance with program regulations.

Outlined below are the various screening and audit procedures used to assure CCare program integrity and reduce risk of overpayment.

It should be noted that it is not the goal of the audit process to impose additional fees or penalties, but rather to recover payments that were made in error or to correct practices that are not in keeping with program regulations.

The Oregon Administrative Rules (OARS) pertaining to CCare are [333-004-3000 through 333-004-3240](#) and include information about the following:

- Requirements for financial, health, and other records
- Review or audit of claims
- Claim redeterminations
- Recovery of overpayment to agencies resulting from review or audit
- Compliance with federal and statute statutes
- Grounds for agency sanctions; sanctions

Types of CCare Audits

The RH Program leverages its multiple sources of funding to reimburse agencies for services rendered. Using a set of system rules based on each funding source's client eligibility and service coverage requirements, the RH Program determines the appropriate fund source to draw from. The RH Program closely monitors monthly claims processing, both to track CCare payments and to assure appropriate use of funds, including adherence to all CCare requirements.

1. Monthly Billing and Claims Data Review

Claims data and billing information are reviewed monthly to ensure proper billing practices and to monitor data collection integrity. An Excel spreadsheet of claims data is received monthly and can be sorted in various ways. The following are examples of what is reviewed through this process:

- Type of visit (low, medium, high) by agency
- Total claims and total payments by agency (for each fund source)
- Type of medical service by agency
- Claims errors/rejects

- Supply billing at acquisition cost (also monitored against invoices)
- Revenue received by third party resources

Each month the billing register is reviewed and a *Billing Register Desk Audit Chart* is used to track any unusual circumstances or findings. The chart contains space to document follow-up needed. Generally, follow-up consists of a phone call or e-mail to the specific agency to discuss the issue. It may be easily resolved over the phone or through e-mail. If the same problem occurs in several agencies at a time, a memo is sent to providers describing the problem and the expected course of action to resolve it. In addition, the RH Program staff can address the problem in future training.

2. Chart Reviews and Desk Audits

Client visit chart notes are requested for review on a routine basis or may be initiated by review of data and billing information (above). Chart notes are reviewed to determine:

- Quality of services
- Chart notes support visit level billed
- Visits billed to CCare are contraceptive management in nature

Client enrollment forms are also reviewed for completeness and accuracy as part of this process and verified against the client eligibility database.

3. CCare Audits During Onsite RHCare Reviews

RHCare clinics are reviewed for compliance with all RHCare Certification Requirements on a triennial basis. Chart reviews are performed as part of the process. Reviewers also follow a checklist of components to review CCare client charts specifically when reviewing charts for RHCare compliance. This review tool is also given to providers to encourage regular self-audit.

4. Client Eligibility and Enrollment

The RH Program executes several processes to verify client eligibility:

- **SSN and Citizenship Verification:** On the first day of each month, state staff generate a list of clients enrolled or re-enrolled in the RH Program during the prior month. State staff use a secure electronic process with the Social Security Administration (SSA) to verify the Social Security Number (SSN) provided by each client at enrollment. This process also verifies clients' citizenship status.
- **Immigration Status Verification:** On the first day of each month, state staff will generate a list of clients enrolled or re-enrolled in the RH Program during the prior month. State staff will select clients that indicated 'Eligible Immigrant Status' on their client enrollment form upon enrollment. State staff review the list of eligible immigrants

and identify clients that had not supplied proof of their immigration status at the time of enrollment into the RH Program, but who have since provided documentation information to their respective clinic staff. State staff use the documentation information to verify immigration status by entering this information into the Systematic Alien Verification for Entitlements (SAVE) system. Results are provided immediately and state staff will either verify a client's immigration status or communicate with clinics to identify reasons preventing this verification. If a client that is an eligible immigrant is unable to have their immigration status verified, their CCare eligibility is terminated following the end of the 90-day Reasonable Opportunity Period (though it should be noted that the client's eligibility for other, non-Medicaid funding sources remains intact).

- **Income Verification:** Every three months, RH Program staff generate a list of all clients enrolled or re-enrolled in the RH Program during the prior quarter. State staff use a secure electronic process with the Oregon Employment Department to find income records for the quarter of enrollment into the RH Program. State staff upload a file with clients' names, SSNs and DOBs to the Employment Department's secure web portal and Employment Department records are automatically searched and matched to the client records. An electronic results file is automatically created. State staff add up each client's total quarterly income and determine whether it is above the eligibility threshold for their household size. Because wage information is only available on a quarterly basis, state staff check income 30 days after the quarter of enrollment ends. Clients who are determined to have average monthly income above the eligibility threshold (based on a maximum of 250% of the Federal Poverty Level for the client's household size) will have their eligibility suspended. Clients are offered the opportunity to correct the discrepancy and can have their eligibility reinstated within 45 days of the suspension date. If eligibility is not reinstated during this time, the client's eligibility will be terminated.

For the above processes, the state will draw down the appropriate federal match for covered services from the time of enrollment until the date the client is determined ineligible.

5. Data Review

Required data elements on CCare claims are reviewed for quality assurance and quality improvement purposes on an annual basis, and prior to any onsite review. Information accessible through claims data includes:

- Percentage of services provided to adolescents and/or low-income families
- Types of medical and counseling services provided

- Variety of contraceptive methods dispensed
- Provision of options counseling

6. Other Requests for Information

The RH Program may request specific information on an as-needed basis.

Types of Findings

1. Administrative

Administrative findings, identified by review or chart audit, are not related to incorrect billing or overpayment, but are program elements not being met. Examples:

- An agency consistently gives only one package of pills per visit
- An agency shows no evidence of billing third party reimbursement
- Items omitted on the Client Enrollment Form

2. Financial

Financial findings identified by chart audit procedure consist of incorrect billing that resulted in overpayment to the provider. The specific OAR for *Recovery of Over-payments to Providers Resulting from Review or Audit* is [333-004-3180](#).

Financial Finding Procedure:

- Overpayment is established through chart audit and documented in the matrix of findings.
- Amount of overpayment may be calculated by extrapolation of the random sample or may be actual overpayment.
- A cover letter and notice of overpayment (invoice) is sent.
- Agency has a 10-day period to review the matrix/chart audit findings and to discuss or refute the findings with the auditor.
- Claims that are determined to be billed in error should be corrected and resubmitted during the next monthly billing cycle.
- A repayment agreement may be arranged at the discretion of OHA, using a repayment contract signed by both parties.
- If the audited agency disagrees with the findings, the contested case hearing procedure is followed.

Appendix E: Public Notice and Tribal Consult

1) Start and end dates of the state’s public comment period.

Oregon’s public comment period for the waiver renewal application began on May 1, 2021 and ended on May 31, 2021.

2) Certification that the state provided public notice of the application, along with a link to the state’s web site and a notice in the state’s Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.

Public notification (Appendix E, Attachment 1) of the state’s intent to apply for renewal of the 1115 Demonstration waiver for Oregon ContraceptiveCare and opportunities for public comment was posted to:

- The RH Program’s Certification webpage (Appendix E, Attachment 2)
- Oregon Secretary of State’s Bulletin: Executive Orders and Other Notices for May 2021 (Appendix E, Attachment 3).

3) Certification that the state convened at least 2 public hearings, of which both hearings included teleconferencing and web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.

Two public hearings were scheduled for the public to comment on the waiver renewal on the following dates:

Tuesday, May 11, 2021 11:30 a.m. – 1:30 p.m. https://www.zoomgov.com/j/1602744331?pwd=Sk9CRzFINTdvN3p4d3FtL1BSSEI4Zz09 Meeting ID: 160 274 4331 Passcode: 583068 By phone: +1 669 254 5252, 1602744331# US (San Jose) +1 646 828 7666, 1602744331# US (New York)	Monday, May 24, 2021 3 p.m. – 5 p.m. https://www.zoomgov.com/j/1604958086?pwd=OVFyRTJHb1NwbHFXSEczcm9JOE1zZz09 Meeting ID: 160 495 8086 Passcode: 409808 By phone: +1 669 254 5252, 1604958086# US (San Jose) +1 646 828 7666, 1604958086# US (New York)
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Due to the COVID-19 pandemic, both public hearings were conducted via remote video conferencing. Written comments concerning the waiver renewal were accepted on or before 5:00 pm on May 31, 2021 via postal mail or email to:

Emily Elman
Oregon Reproductive Health Program
Public Health Division

800 NE Oregon Street, Room 370

Portland, OR 97232

Email: emily.l.elman@dhsosha.state.or.us

4) Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used.)

The state used the following electronic mailing lists to notify the public of its intent to submit a waiver renewal application:

- Email to the Reproductive Health Program electronic newsletter recipient list on April 29, 2021. The distribution list for the electronic newsletter includes over 440 recipients, including local providers, local and state community partner agencies, and community based organizations. (Appendix E, Attachment 4)
- Notice to the Oregon Health Plan stakeholder's update listserv on April 29, 2021. The notice was sent to 8,821 subscribers of the stakeholder listserv. (Appendix E, Attachment 5)

5) Comments received by the state during the 30-day public notice period.

Two written comments, submitted via email, were received during the 30-day public notice period. The first comment was from a citizen writing in support of the waiver. "I strongly support the OHA Medicaid waiver for Contraceptive Care. All women deserve reproductive health and contraceptive care. Especially related to education related to preventing unwanted pregnancies, STI's and breast/cervical cancer. Reproductive care is healthcare. For those that oppose abortion rights, this is the best and most effective prevention for unwanted pregnancies resulting in abortion. Please allow this waiver to ensure Oregon women receiving their healthcare via Medicaid receive the contraceptive care they need and deserve."

The second comment expressed concern, "I see this as too easily green-lighting Abortion on Demand. I generally oppose abortion, although all the institutional framework here is obviously pro. There is no discussion of alternatives, and the impetus to provide here seems hungry to over-provide to establish enlarging projects."

6) Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application.

Neither of the two comments received necessitated any changes to the final application.

7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State plan, or at least 60

days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation.

Formal notice of tribal consultation regarding the state's intent to submit the waiver renewal application was sent by email on April 13, 2021 to the tribal health directors and representatives of the nine federally recognized tribes in Oregon. A copy of the notice and the email distribution list is included as Appendix E, Attachment 6. No comments were received.



PUBLIC HEALTH DIVISION

Kate Brown, Governor



Public Notice

Reproductive Health Program
800 NE Oregon St., Suite 370
Portland, OR 97232
Voice: (971) 673-0355
FAX: (971) 673-0371

Date: April 29, 2021

Subject: Notice of intent to submit Section 1115 Waiver renewal application for the Oregon Contraceptive Care Program

The Reproductive Health (RH) Program, within the Public Health Division of the Oregon Health Authority (OHA), provides this legal notice of a public review and comment period concerning the state's intent to submit a renewal of the Section 1115 Medicaid waiver for Oregon ContraceptiveCare (CCare) to the Centers for Medicare & Medicaid Services (CMS) for the period of January 1, 2022 through December 31, 2026. The public comment period begins May 1, 2021 and ends May 31, 2021.

First approved in 1998 by CMS, CCare expands Medicaid coverage for family planning services to individuals of reproductive age with incomes at or below 250% of the federal poverty level.

Key attributes of CCare include:

- *Client eligibility and enrollment:* Individuals of reproductive age, at or below 250% FPL, and not enrolled in OHP may complete a client enrollment form at the clinic site and receive same-day coverage for family planning services and contraceptives.
- *Covered services:* CCare-covered services include a broad range of contraceptives, counseling and education to assist with preventing pregnancy, sexually transmitted infection (STI) screening, and breast and cervical cancer screening within the context of a family planning visit.
- *Clinic network:* The CCare provider network consists of over 140 clinics statewide including local public health departments, federally qualified health centers, Planned Parenthood clinics, school-based health centers, University health centers, and small community health clinics.

The application explains how OHA's RH Program proposes to continue administration of the CCare waiver for the five-year waiver renewal period. The full application is available for review at <http://healthoregon.org/rhcertification>. Additional information about the state's waiver can be found on the CMS' website [here](#).

Opportunities for public comment will be held remotely during the following dates and times:

<p>Tuesday, May 11, 2021 11:30 a.m. – 1:30 p.m. https://www.zoomgov.com/j/1602744331?pwd=Sk9CRzFINTdvN3p4d3FtL1BSSEI4Zz09 Meeting ID: 160 274 4331 Passcode: 583068 By phone: +1 669 254 5252, 1602744331# US (San Jose) +1 646 828 7666, 1602744331# US (New York)</p>	<p>Monday, May 24, 2021 3 p.m. – 5 p.m. https://www.zoomgov.com/j/1604958086?pwd=OVFyRTJHb1NwbHFXSEczcm9JOE1zZz09 Meeting ID: 160 495 8086 Passcode: 409808 By phone: +1 669 254 5252, 1604958086# US (San Jose) +1 646 828 7666, 1604958086# US (New York)</p>
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In addition to verbal comments during the two meetings above, written comments concerning the waiver renewal may also be submitted on or before 5 p.m. on May 31, 2021 to: Emily Elman, Oregon Reproductive Health Program, Public Health Division; 800 NE Oregon Street, Suite 370; Portland, OR 97232 or at emily.l.elman@dhsosha.state.or.us.

Screen Shot – Public Notice on State’s Website

ATIVESEXUALHEALTH/RESOURCES/Pages/Certification.aspx#ccare

gram Pages Thesaurus.com Reimagine Oregon GA The Guide to Allyship Smartsheet gif of old lady hittin... Ask a Manager

Health Plan ▾ Health System Reform ▾ Licenses and Certificates ▾ Public Health ▾

1. Read the CCare Certification Packet thoroughly.
2. Contact the RH Program at rh.program@state.or.us.

For questions about the certification process or requirements, please email rh.program@state.or.us

Proposed CCare Waiver Renewal Draft Application

The Reproductive Health (RH) Program, within the Public Health Division of the Oregon Health Authority (OHA), provides this legal notice of a public review and comment period concerning the state's intent to submit a renewal of the Section 1115 Medicaid waiver for Oregon ContraceptiveCare (CCare) to the Centers for Medicare & Medicaid Services (CMS) for the period of January 1, 2022 through December 31, 2026. The public comment period begins May 1st, 2021 and ends May 31st, 2021.

First approved in 1998 by CMS, CCare expands Medicaid coverage for family planning services to individuals of reproductive age with incomes at or below 250% of the federal poverty level.

Key attributes of CCare include:

- *Client eligibility and enrollment:* Individuals of reproductive age, at or below 250% FPL, and not enrolled in OHP may complete a client enrollment form at the clinic site and receive same day coverage for family planning services and contraceptives.
- *Covered services:* CCare-covered services include a broad range of contraceptives, counseling and education to assist with preventing pregnancy, sexually transmitted infection (STI) screening, and breast and cervical cancer screening within the context of a family planning visit.
- *Clinic network:* The CCare provider network consists of over 140 clinics statewide including local public health departments, federally qualified health centers, Planned Parenthood clinics, school-based health centers, University health centers, and small community health clinics.

The application explains how OHA's RH Program proposes to continue administration of the CCare waiver for the five-year waiver renewal period. [Read the full application](#). See additional information about the state's waiver on [CMS' website](#).


Opportunities for public comment will be held remotely during the following dates and times:

- **Tuesday, May 11, 2021**
11:30 am - 1:30 pm
<https://www.zoomgov.com/j/1602744331?pwd=Sk9CRzFINTdvN3p4d3FiL1BSSEI4Zz09>
Meeting ID: 160 274 4331
Passcode: 583068
By phone:
+1 669 254 5252, 1602744331# US (San Jose)
+1 646 828 7666, 1602744331# US (New York)
- **Monday, May 24, 2021**
3:00 pm – 5:00 pm
<https://www.zoomgov.com/j/1604958086?pwd=OVYyRTJHb1NwbHFXSEczcm9JOE1zZz09>
Meeting ID: 160 495 8086
Passcode: 409808
By phone:
+1 669 254 5252, 1604958086# US (San Jose)
+1 646 828 7666, 1604958086# US (New York)

In addition to verbal comments during the two meetings above, written comments concerning the waiver renewal may also be submitted on or before 5:00 pm on May 31st to Emily Elman Oregon Reproductive Health Program, Public Health Division; 800 NE Oregon Street, Suite 370; Portland, OR 97232, or at emily.elman@dhs.oregon.gov.

Screen Shot – Oregon Secretary of State’s Bulletin: Executive Orders and Other Notices for May 2021

OtherNotices-May-2021 [View / Download](#)

 PUBLIC HEALTH DIVISION
Kate Brown, Governor

Public Notice

Date: April 29, 2021

Subject: Notice of intent to submit Section 1115 Waiver renewal application for the Oregon Contraceptive Care Program

Reproductive Health Program
800 NE Oregon St., Suite 370
Portland, OR 97232
Voice: (971) 673-0355
FAX: (971) 673-0371

The Reproductive Health (RH) Program, within the Public Health Division of the Oregon Health Authority (OHA), provides this legal notice of a public review and comment period concerning the state's intent to submit a renewal of the Section 1115 Medicaid waiver for Oregon ContraceptiveCare (CCare) to the Centers for Medicare and Medicaid Services (CMS) for the period of January 1, 2022 through December 31, 2026. The public comment period begins May 1st, 2021 and ends May 31st, 2021.

First approved in 1998 by CMS, CCare expands Medicaid coverage for family planning services to individuals of reproductive age with incomes at or below 250% of the federal poverty level.

Key attributes of CCare include:

From: BABICH Alison A

Bcc: "ava.elli@211info.org"; "billing.ablhc@yahoo.com"; "info@abalancedlifehealthcare.com"; "rich@ahlerssoftware.com"; "kevin.whitley@allcarehealth.com"; "Jeff.Moore@allcarehealth.com"; "calliman@umpquachc.org"; "elarsen@umpquachc.org"; "njones@umpquachc.org"; "randolph@umpquachc.org"; "achvilcek@umpquachc.org"; "kgandy@umpquachc.org"; "swheelock@umpquachc.org"; "mstoddard@umpquachc.org"; "kcarhart@umpquachc.org"; "bcharles@umpquachc.org"; "mmckee@umpquachc.org"; "bhickam@umpquachc.org"; "sspegal@umpquachc.org"; "crutledge@umpquachc.org"; "mmcallister@umpquachc.org"; Bourne LeAnne; "ttalbott@bakercounty.org"; "nstaten@bakercounty.org"; Lovisone Tracy; "brooke.cottle@bethel.k12.or.us"; "angela.bradley@bethel.k12.or.us"; "sandra.smith@co.benton.or.us"; "Juana.LITTLE@co.benton.or.us"; "Yaquelin.Ramos@co.benton.or.us"; "kelly.volkman@co.benton.or.us"; Yager Charlene R; "rebecca.fisher@co.benton.or.us"; "stacy.ramirez@co.benton.or.us"; "christine.mosbaugh@co.benton.or.us"; "Susan.Wolff@co.benton.or.us"; "lizdaly.cancel@co.benton.or.us"; "lanoi.case@co.benton.or.us"; "ann.walker@co.benton.or.us"; "Denise.Gee@co.benton.or.us"; "charlene.jones@co.benton.or.us"; "lori.mckay@co.lane.or.us"; "jessica.alvarado@co.lane.or.us"; "lisa.willis@co.lane.or.us"; "karen.shelgren@co.lane.or.us"; "jordan.humphrey@lanecounty.gov"; Gaffney Karen; "Rowena.THORNTON@lanecounty.gov"; "Jocelyn.warren@co.lane.or.us"; "Kandice.SHERIDAN@lanecounty.gov"; "melisa.lyle@co.benton.or.us"; "erika.huston@co.lane.or.us"; "Asuchocki@co.clackamas.or.us"; "aamundson@co.clackamas.or.us"; "SRoy@co.clackamas.or.us"; "mrusso@co.clackamas.or.us"; "KCollins2@co.clackamas.or.us"; "PCalvert@co.clackamas.or.us"; "vmcintyre@co.clackamas.or.us"; "sjacobson@co.clackamas.or.us"; "ssalber@co.clatsop.or.us"; "dbergeson@co.clatsop.or.us"; "ssalber@co.clatsop.or.us"; "terfling@co.clatsop.or.us"; Jeffrey Holly; McClean Lisa; "tiempea@co.clatsop.or.us"; "stacyyanase@gmail.com"; "oregonclho@gmail.com"; "barbaras@coastcommunityhealth.org"; "RandellS@coastcommunityhealth.org"; 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Subject: #u# Notice of CCare Renewal Application Public Comment Period
Date: Thursday, April 29, 2021 4:57:00 PM
Attachments: [image001.png](#)

Good afternoon,

The RH Program intends to submit an application for the renewal of its Section 1115 Medicaid waiver for Oregon ContraceptiveCare (CCare) to the Centers for Medicare & Medicaid Services (CMS) for the period of January 1, 2022 through December 31, 2026. Public notice is attached.

The public comment period begins May 1, 2021 and ends May 31, 2021, and the full application is available for review at <http://healthoregon.org/rhcertification>. Additional information about the state's waiver can be found on the CMS' website [here](#).

We will be hosting two opportunities for public comment:

<p>Tuesday, May 11, 2021 11:30 a.m. – 1:30 p.m. https://www.zoomgov.com/j/1602744331?pwd=Sk9CRzFINTdvN3p4d3FtL1BSSEl4Zz09 Meeting ID: 160 274 4331 Passcode: 583068 By phone: +1 669 254 5252, 1602744331# US (San Jose) +1 646 828 7666, 1602744331# US (New York)</p>	<p>Monday, May 24, 2021 3 p.m. – 5 p.m. https://www.zoomgov.com/j/1604958086?pwd=OVFyRTJHb1NwbHFXSEczcm9JOE1zZz09 Meeting ID: 160 495 8086 Passcode: 409808 By phone: +1 669 254 5252, 1604958086# US (San Jose) +1 646 828 7666, 1604958086# US (New York)</p>
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In addition to verbal comments during the two meetings above, written comments concerning the waiver renewal may also be submitted on or before 5 p.m. on May 31, 2021 to: Emily Elman, Oregon Reproductive Health Program, Public Health Division; 800 NE Oregon Street, Suite 370; Portland, OR 97232 or at emily.l.elman@dhsosha.state.or.us.

As always, let us know if you have any questions.

The RH Team

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**Alison A. Babich, JD**

(Pronouns: she/her)

Operations & Agency Coordinator,  
Oregon Reproductive Health Program  
OREGON HEALTH AUTHORITY

[alison.a.babich@state.or.us](mailto:alison.a.babich@state.or.us)

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**I work Monday – Thursday, off Fridays**



Find us on: [Facebook](#) and [Instagram](#)

**AGRH Racial Equity Policy:** The Adolescent, Genetics and Reproductive Health (AGRH) Section commits to working towards racial equity by addressing racism, acknowledging implicit bias, and shifting how we do what we do. We accept that our commitment to diversity, equity and inclusion (DEI) means a commitment to constant learning – we will make mistakes, but we are determined to learn from them and to improve.

*To read the full version of our Commitment please go to our [website](#).*

## Notice to Oregon Health Plan Stakeholder's Update Listserv

This is a courtesy copy of an email bulletin sent by Kim Witbeck.

This bulletin was sent to the following groups of people:

Subscribers of OHA-HSD-OHP Stakeholder Updates (8821 recipients)



**Date:** April 29, 2021

**Contact:** Emily Elman, Senior Policy Analyst

**Comments due:** 5 p.m. Monday, May 31, 2021

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The Oregon Health Authority (OHA) will submit an application to renew the Section 1115 Medicaid waiver for Oregon's ContraceptiveCare (CCare) program for the period of January 1, 2022, through December 31, 2026. The public comment period begins May 1, 2021 and ends May 31, 2021.

OHA welcomes public input. To learn more, [read the public notice from OHA](#).

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**Let's be friends!**







TRIBAL AFFAIRS

Kate Brown, Governor



500 Summer Street NE, E-86  
Salem, OR 97301-1118  
Desk: 503-945-9703

April 13, 2021

Dear: Tribal Leader

In an ongoing effort to consult with Oregon's Nine Federally Recognized Tribes and confer with the Urban Indian Health Program on issues that may impact the Tribes and the health of their members, this letter is being sent to inform you of an identified critical event.

The Oregon Reproductive Health (RH) Program, within the Public Health Division of the Oregon Health Authority, is seeking a five-year renewal of its family planning Medicaid 1115 demonstration waiver program entitled, Oregon ContraceptiveCare (CCare), for the period of January 1, 2022 through December 31, 2026. The RH Program intends to submit the waiver renewal application to the Centers for Medicare and Medicaid Services (CMS) no later than June 30, 2021.

### Background

First approved in 1998 by CMS, CCare expands Medicaid coverage for family planning services to individuals of reproductive age with incomes at or below 250% of the federal poverty level. CCare is unique as a Medicaid program in that it is administered by the RH Program within the Public Health Division and is integrated with the RH Program's other funding sources to create a streamlined reproductive health service delivery system for both clients and participating clinics.

#### Key attributes of CCare:

- *Client eligibility and enrollment:* Individuals of reproductive age, at or below 250% FPL, and not enrolled in OHP may complete a client enrollment form at the clinic site and receive same day coverage for family planning services and contraceptives.
- *Covered services:* CCare-covered services include a broad range of contraceptives, counseling and education to assist with preventing pregnancy, sexually transmitted infection (STI) screening, and breast and cervical cancer screening within the context of a family planning visit.
- *Clinic network:* The CCare provider network consists of over 140 clinics statewide including local public health departments, federally qualified health centers, Planned Parenthood clinics, school-based health centers, University health centers, and small community health clinics.

#### Unique characteristics of CCare:

- Client enrollment occurs at the clinic site, using a shorter enrollment form than OHP, and eligible clients are then able to receive services and contraceptives the same day.
- Clients receive their contraceptive method of choice at their appointment, eliminating the need to go to a second location (e.g., pharmacy).
- Participating clinics must meet high-quality, client-centered, and culturally responsive standards of care and follow a robust set of program integrity procedures.
- Clinics are required to coordinate care with and refer clients to local community-based health and service agencies, as appropriate.

**Anticipated impact**

OHA does not foresee a direct impact on American Indians/Alaska Natives, Indian Health Service, Tribal Health Programs or the Urban Indian Health Programs (I/T/U) as a result of this waiver renewal. Currently, no I/T/U participate in CCare.

OHA invites you to review the attached CCare waiver renewal application for further information. In particular, 'Appendix A: Historical Narrative Summary and Program Overview' of the attached document provides pertinent information about the CCare program and the upcoming waiver renewal request.

If you would like to participate in a formal consultation to discuss this topic please let Julie Johnson know via email by May 13, 2021 so that we can get it scheduled. If a formal consultation is not needed; we invite you to provide any comments, suggestions, or questions to Emily Elman, RH Program Senior Policy Analyst, at [emily.l.elman@dhs.oha.state.or.us](mailto:emily.l.elman@dhs.oha.state.or.us). The RH Program also welcomes further discussion regarding any interest in participating as a CCare clinic.

Sincerely,

Julie Johnson  
Tribal Affairs Director

**Email Distribution List for Tribal Consultation:**

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